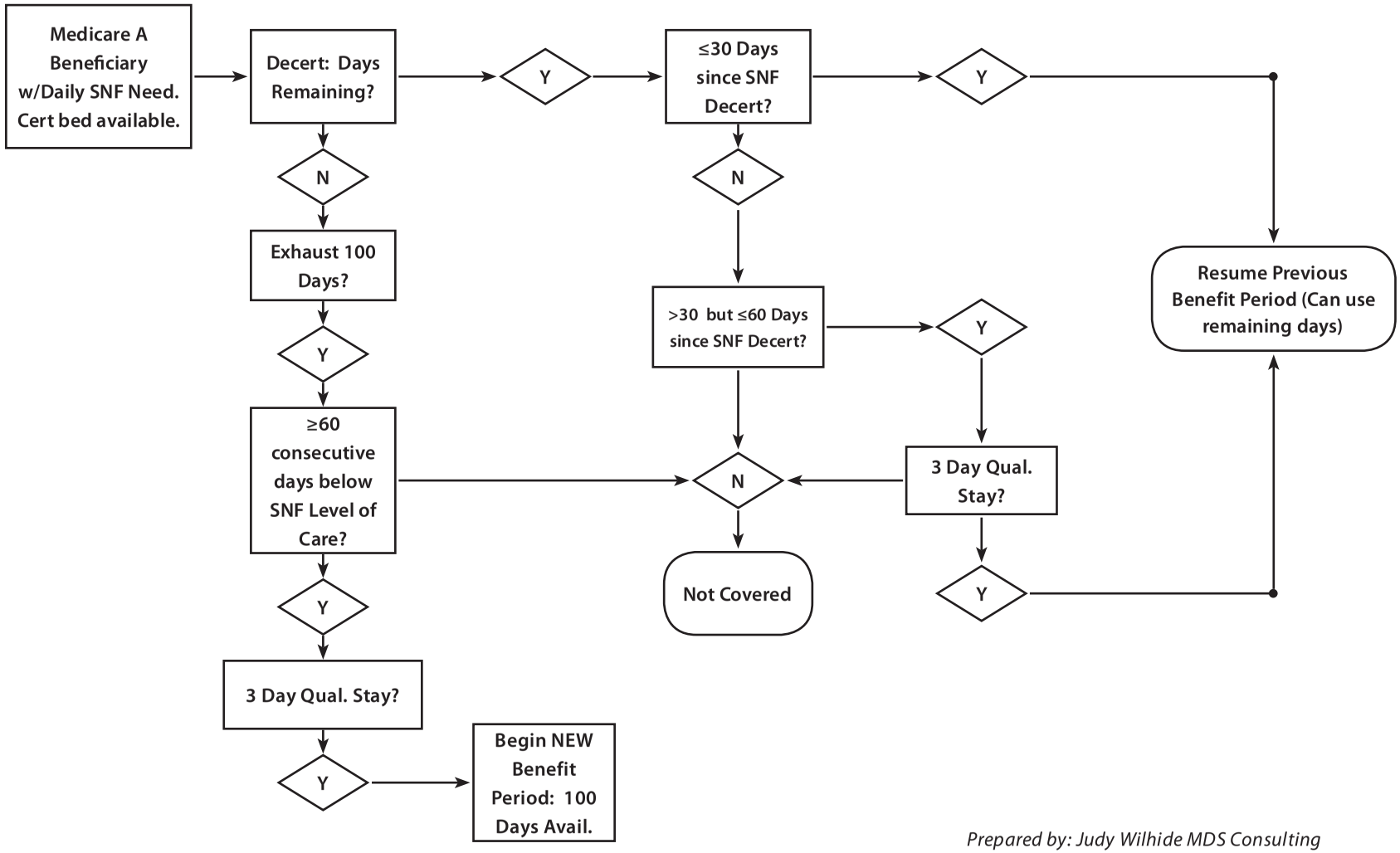
SNF Medicare Benefit Period Flow Chart*

*Refer to applicable Medicare Regulations for definitions

Subsequent Use of Benefit Period:
Beneficiary has previously used Medicare SNF Days



Prepared by: Judy Wilhide MDS Consulting

Benefit Period Examples

Example I Mr. Smith was born August 9, 1932. On July 28, 2012, Mr. Smith entered a participating general hospital. On August 11, 2012, after he had been in the hospital for two weeks, Mr. Smith was discharged. On his doctor's orders, Mr. Smith entered a participating skilled nursing facility on August 15, 2012, and remained an inpatient there until his discharge on October 27, 2012. He had no further inpatient stays in 2012. Mr. Smith's benefit period began on August 1, 2012, the first day of the month he attained age 65 and was entitled to hospital insurance. The benefit period ended December 25, 2012, the end of the 60-day period beginning with the date of his last discharge.

Example 2 Mrs. Allen, over age 65, entered a participating general hospital on July 28, 2011, for treatment of a heart condition. She was discharged on August 11, 2011. On August 20, 2011, Mrs. Allen entered a Medicaid-only nursing home that provided primarily skilled nursing care and related services. Mrs. Allen remained an inpatient [by Medicare's definition, receiving a Medicare skilled level of care even though Medicare Part A was not available in this nursing home] in this facility until her discharge on October 27, 2011. On December 25, 2011, she was again admitted to a participating hospital because of injuries suffered in an accident. She was discharged on January 13, 2012, and had no further inpatient stays in 2012.

Mrs. Allen's benefit period began on July 28, 2011. Her stay in the nursing home began less than 60 days after her hospital discharge, and therefore the benefit period was continued even though the stay was not covered. The subsequent hospital stay began less than 60 days after the nursing home discharge and therefore continued the benefit period, although the condition treated was unrelated to her prior stays. The period ended March 13, 2012, the end of the 60-day period, beginning with the day of discharge, during which she had no inpatient hospital stays and did not receive a skilled level of care in an SNF.

Example 3 Mr. Jackson, age 82, was admitted to a participating hospital for a qualifying stay on January 1, 2012. He was discharged to Convalescent Home on January 5, 2012, for post-CVA care. He received 100% of his nutritional support from a PEG tube. Mr. Jackson received skilled care on a daily basis and exhausted his benefits on April 10, 2012, the end of his 100 days of coverage in the benefit period. He continued to require the same level of care and on November 10, 2012, was admitted to the hospital for treatment of a broken hip.

Upon readmission to the home on November 14, Mr. Jackson would not qualify for any SNF benefit days as he did not have a 60-day period without a skilled level of care in an SNF or a hospital. The new diagnosis does not create a new benefit period.

Example 4 Mr. Jackson, age 82, was admitted to a participating hospital for a qualifying stay on January 1, 2012. He was discharged to Convalescent Home on January 5, 2012, for post-CVA care. He received 100% of his nutritional support from a PEG tube. Mr. Jackson received skilled care on a daily basis and exhausted his benefits on April 10, 2012, the end of his 100 days of coverage in the benefit period. On May 1, 2012, Mr. Jackson began eating solid food, had the PEG removed, and required only custodial care from that day. On November 10, 2012, Mr. Jackson was admitted to the hospital for treatment of a broken hip.

Upon readmission to the home on November 14, Mr. Jackson would qualify for up to another 100 SNF benefit days as there was the required 60-day break in his benefit period from May 1 through November 10 (i.e., he fell below a skilled level of care for at least 60 days).

Skilled Rehabilitation Examples

Example 1 Jonas Reese was admitted to the SNF after a four-day inpatient hospital stay for a urinary tract infection. The infection was resolved on admission to the SNF, although he was still taking oral antibiotics. He was tired from the illness and required some hands-on assistance for safety when walking when he had been independent with a cane before his illness. He was picked up on Part A for skilled physical therapy for gait training and occupational therapy for ADLs, all related to decreased endurance. On medical review the therapy was denied. A review of the chart revealed:

- There was no evidence in the chart that Mr. Reese had a neurological, muscular, or skeletal impairment necessitating gait training.
- The record did not support the need for a level of complexity that justified the need for a skilled therapist for therapeutic exercises.
- His prior level of function with ADLs was essentially the same as it was on admission to the SNF.

Example 2 Rita Connolly, a 67-year-old business executive, was admitted to the nursing home after hospitalization for a CVA with left-sided hemiplegia. On admission to the SNF, she was alert but confused, unable to stand on her feet due to the hemiplegia and balance deficits. She was occasionally able to follow instructions. Physical therapy and occupational therapy picked her up. They covered her for 65 days. On discharge from Part A, she was unable to walk and participated minimally in ADL activities. On claim review, the first 21 days of the stay were paid as billed. The remainder of the therapy was denied. A review of the chart revealed that, while her deficits were clearly documented:

- She was unable to consistently follow directions
- She demonstrated poor carry-over from one session to another
- The progress that she made essentially was related to automatic functions and activities that often spontaneously return rather than the result of learning.
- The progress she made was insignificant in relation to the extent and duration of the therapy services required to achieve the results.

SNF DENIAL LETTER EXHIBIT 1

INTERMEDIARY DETERMINATION OF NONCOVERAGE

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date), the Medicare intermediary advised us that the services you receive will no longer qualify as covered under Medicare beginning (Date).

The Medicare intermediary will send you a formal determination as to the noncoverage of your stay after (Date). If you wish to appeal, the formal notice will contain information about how this can be done. The intermediary will inform you of the reason for denial and your appeal rights.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier, in person or by telephone, were unsuccessful. Please verify receipt of this notice by signing below.

Sincerely yours,

_____

Signature of Administrative Officer

SNF DENIAL LETTER EXHIBIT 1 (cont.)

VERIFICATION OF RECEIPT OF NOTICE

A. This acknowledges that I received this attached notice of noncoverage of services under Medicare on (date of receipt).

_____

(Signature of Beneficiary or Person
acting on Beneficiary's behalf)

B. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____

(Name of Beneficiary or
Representative contacted)

_____

(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

SNF DENIAL LETTER EXHIBIT 2

UR COMMITTEE DETERMINATION OF ADMISSION

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date), our Utilization Review Committee reviewed your medical information available at the time of, or prior to your admission, and advised us that the services (you or beneficiary's name) needed do not meet the requirements for coverage under Medicare. The reason is:

(Insert specific reason the services were determined to be noncovered.)

This decision has not been made by Medicare. It represents the Utilization Review Committee's judgment that the services you needed did not meet Medicare payment requirements. Normally, under this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request us to submit one. Furthermore, if you want to appeal this decision you must request that a bill be submitted. If you request a bill be submitted, the Medicare intermediary will notify you of its determination. If you disagree with that determination you may file an appeal.

You must also request that a bill be submitted to Medicare if you have questions concerning your liability for payment for the services you received.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____

Signature of Administrative Officer

SNF DENIAL LETTER EXHIBIT 2 (cont.)

REQUEST FOR MEDICARE INTERMEDIARY REVIEW

/__ / A. I want my bill submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.
If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

/__ / B. I do not want my bill submitted to the intermediary for a Medicare decision. I understand that I do not have Medicare appeal rights if a bill is not submitted. NOTE: You are not required to pay for services until a Medicare decision has been made.

VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received the notice of noncoverage of services under Medicare on (date of receipt).

_____

(Signature of Beneficiary or Person acting on Beneficiary's behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____

(Name of Beneficiary or Representative contacted)

_____

(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

SNF DENIAL LETTER EXHIBIT 3

UR COMMITTEE DETERMINATION ON CONTINUED STAY

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date) our Utilization Review Committee reviewed your medical information and found that the services furnished (you or beneficiary's name) no longer qualified for payment by Medicare beginning (Date).

The reason for this is: (Insert specific reason services were determined to be noncovered).

This decision has not been made by Medicare. It represents the Utilization Review Committee's judgment that the services you needed no longer met Medicare payment requirements. A bill will be sent to Medicare for the covered services you received before (Date). Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision you must request that the bill submitted to Medicare include the services our URC determined to be noncovered. Medicare will notify you of its determination. If you disagree with that determination you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want the bill for services after (date) submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____

Signature of Administrative Officer

SNF DENIAL LETTER EXHIBIT 3 (cont.)

REQUEST FOR MEDICARE INTERMEDIARY REVIEW

/__ / A. I want my bill for services I continue to receive to be submitted to the intermediary for a Medicare decision. You will be notified when the bill is submitted. If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

/__ / B. I do not want my bill for services submitted to the intermediary for a Medicare decision.
I understand that I do not have Medicare appeal rights if a bill is not submitted.
NOTE: You are not required to pay for services until a Medicare decision has been made.

VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received this notice of noncoverage of services under Medicare on (date of receipt).

_____

(Signature of Beneficiary or Person
acting on Beneficiary's behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____

(Name of Beneficiary or
Representative contacted)

_____

(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

SNF DENIAL LETTER EXHIBIT 4

SNF DETERMINATION ON ADMISSION

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date), we reviewed your medical information available at the time of, or prior to your admission, and we believe that the services (you or beneficiary's name) needed did not meet the requirements for coverage under Medicare. The reason is:

(Insert specific reason services are determined to be noncovered.)

This decision has not been made by Medicare. It represents our judgment that the services you needed did not meet Medicare payment requirements. Normally, under this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request that a bill be submitted. Furthermore, if you want to appeal this decision, you must request that a bill be submitted. If you request that a bill be submitted, the Medicare intermediary will notify you of its determination. If you disagree with that determination, you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

If you have questions concerning your liability for payment for services you received prior to the date of this notice, you must request that a bill be submitted to Medicare.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____

Signature of Administrative Officer

SNF DENIAL LETTER EXHIBIT 4 (CONT.)

REQUEST FOR MEDICARE INTERMEDIARY REVIEW

/__ / A. I want my bill submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.
If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

/__ / B. I do not want my bill submitted to the intermediary for a Medicare decision. I understand that I do not have Medicare appeal rights if no bill is submitted. NOTE: You are not required to pay for services until a Medicare decision has been made.

VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received this notice of noncoverage of services under Medicare on (date of receipt).

_____

(Signature of Beneficiary or Person
acting on Beneficiary's behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____

(Name of Beneficiary or
Representative contacted)

_____

(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

SNF DENIAL LETTER EXHIBIT 5

SNF DETERMINATION ON CONTINUED STAY

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date), we reviewed your medical information and found that the services furnished (you or beneficiary's name) no longer qualified as covered under Medicare beginning (Date).

The reason is: (Insert specific reason services are considered noncovered.)

This decision has not been made by Medicare. It represents our judgment that the services you needed no longer met Medicare payment requirements. A bill will be sent to Medicare for the services you received before (Date). Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision, you must request that the bill submitted to Medicare include the services we determined to be noncovered. Medicare will notify you of its determination. If you disagree with that determination you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____

Signature of Administrative Officer

SNF DENIAL LETTER EXHIBIT 5 (cont.)

REQUEST FOR MEDICARE INTERMEDIARY REVIEW

/__ / A. I want my bill for services I continue to receive to be submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted. If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

/__ / B. I do not want my bill for services I continue to need to be submitted to the intermediary for a Medicare decision.
I understand that I do not have Medicare appeal rights if a bill is not submitted.
NOTE: You are not required to pay for services until a Medicare decision has been made.

VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received this notice of noncoverage of services under Medicare on (date of receipt).

_____

(Signature of Beneficiary or Person
acting on Beneficiary's behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____

(Name of Beneficiary or
Representative contacted)

_____

(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

Instructions for Completion of Denial Letters

Make an original and two copies. (If the intermediary requires a copy, make one more copy.) Give, or where this is not possible, mail the original to the beneficiary (or person acting on his behalf). Send the first copy to the patient's attending physician, keep the second. When a copy is given a beneficiary (or person acting on his behalf), keep a copy containing the signature of the beneficiary (or person acting on his behalf), acknowledging the date the notice was received. Where personal delivery is not possible, your copy reflects the date the beneficiary was notified by telephone and the date the notice was mailed.

A. **Heading of Letter**—Select the appropriate letter.

1. **SNF Designation**—Enter your name and address at the top.
2. **Date Line**—Enter the date you give or mail the letter to the beneficiary or his representative.
3. **Addressee Line**—Enter the name of the beneficiary (or the person acting on his behalf) and if the letter is mailed, the address of the beneficiary (or the person acting on his behalf). Position the name and address properly if a window envelope is used.
4. **Re Line**—Where the letter is addressed to a person acting on behalf of the beneficiary, enter the name of the beneficiary. In all cases, however, enter the beneficiary's HICN and the date of admission.

B. **Body of Letter**—Complete as follows.

1. **Dates**—Insert per instructions below for the appropriate letter.
2. **Reason Noncovered**—Insert the specific explanation citing the medical facts in the case or select and insert the paragraph [see below] best describing the specific reason services are noncovered.
3. **Notification**—Include all required notices. These are stated in the contents of each model letter.

   Letter 1—Use where you are advised of the noncoverage of services by your intermediary. Insert the date the covered care ended.

   Letter 2—Use where you are advised by your URC that the stay was not medically necessary upon admission. Insert the date of the first day on which the stay is not medically necessary.

   Letter 3—Use where the URC advises you that a further stay is not medically necessary. Insert the date of the first day on which the stay is not medically necessary.
   NOTE: This notice is not a replacement for, but is in addition to, required URC notices. This notice protects you from liability in the event the beneficiary, for some reason, does not receive the URC notice.

   Letter 4—Use where you determine prior to, or upon admission, that the services will not be covered.

   Letter 5—Use where you determine that further services will not be covered. Insert the first day on which the services are not covered, usually the day following the date of the notice.

C. **Phone Contact**—Unsuccessful. An in-person or phone contact could not be made with the beneficiary or the person acting on behalf of the beneficiary. Mail the letter on the same day the contact was attempted.

D. **Signature of Administrative Officer**—Your administrative officer or his agent signs.

E. **Beneficiary Acknowledgements**—Request for Medicare intermediary review:
- The beneficiary or the person acting on behalf of the beneficiary checks one of the boxes indicating whether or not he wants the bill to be submitted to the intermediary and signs the notice.
- *Verification of Receipt*—Complete the appropriate item to verify that notice of noncoverage was issued to the beneficiary or to the person acting on his behalf. (If the beneficiary or the person acting on his behalf refuses to sign the verification, annotate your copy of the letter accordingly. Indicate the circumstances and persons involved.)

Coverage Determination (Denial) Letter Paragraphs

The paragraphs provided for insertion into the templates cover common reasons SNF services are noncovered under Medicare. According to *The Skilled Nursing Facility Manual*:

- Where there is no paragraph to explain the reason you or the URC believe services to be noncovered, develop or modify the language to fit the situation.
- Forward to your intermediary for submission to [CMS] language which you develop and use frequently. The language will be reviewed and included in the manual as appropriate.
  NOTE: If applicable, substitute therapy and type of therapist for skilled nursing and skilled nurse.
- If applicable, substitute URC for we, e.g., we or URC believe that the services you received are noncovered.
- If applicable for admission denial letters, adjust the verb inflections or tense.

SNF-1
Condition—Nonskilled care—full denial.
Paragraph—Medicare covers medically necessary skilled nursing care needed on a daily basis. You only needed oral medications, assistance with your daily activities and general supportive services. There is no evidence of medical complications or other medical reasons that required the skills of a professional nurse or therapist to safely and effectively carry out your plan of care. Therefore, we believe that your care cannot be covered under Medicare.

SNF-2
Condition—Specific nonskilled service provided—no skilled care (full denial).
Paragraph—Medicare covers medically necessary skilled care needed on a daily basis. You only needed (specify service). This does not require the skills of a licensed nurse to perform the service or to manage your care. Since you needed neither skilled nursing nor skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare.

SNF-3
Condition—Specific nonskilled service provided—(partial denial).
Paragraph—Medicare covers medically necessary skilled care needed on a daily basis. You only needed (specify service) after (Date). Since you no longer required skilled nursing and did not need skilled rehabilitation on a daily basis, we believe your stay beginning (Date) is not covered under Medicare.

SNF-4
Condition—Observation and management of care plan—no significant change.
Paragraph—Medicare covers medically necessary skilled care needed on a daily basis. You needed skilled nursing care beginning (Date) to observe and evaluate your condition. There is no indication of further likelihood of significant changes in your care plan or of acute changes or complication in your condition. Since you no longer need skilled nursing or skilled rehabilitation services on a daily basis, we believe your stay after (Date) is not covered under Medicare.

SNF-5
Condition—Observation and management of care plan—condition improved.
Paragraph—Medicare covers medically necessary skilled care needed on a daily basis. Because of your condition, you needed a skilled nurse from (Date) through (Date) to evaluate and manage your care plan. Your condition has improved so the services you need can safely and effectively be given by nonskilled persons. Since you no longer require skilled nursing and did not need skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare after (Date).

SNF-6A
Condition—Teaching and training activities—partial denial.
Paragraph—Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You had learned to perform the tasks ordered by your physician by (Date) but the therapist continued services. Since you did not need skilled services after that date, we believe your stay is not covered under Medicare beginning (Date).

SNF-6B
Condition—Teaching and training activities—no skilled service.
Paragraph—Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You needed only to be reminded to follow the physician's instructions. This does not require the skills of a professional nurse or therapist. Therefore, we believe that this service is not covered under Medicare.

SNF-6C
Condition—Teaching and training activities—little or no progress.
Paragraph—Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You received teaching and training for a reasonable time but demonstrated you were not able, at this time, to learn or make progress to perform the activities ordered by your physician. Therefore, we believe that skilled services are not covered under Medicare after (Date).

SNF-7
Condition—Nursing not needed for foley care.
Paragraph—Medicare covers daily skilled nursing care related to the insertion, sterile irrigation and replacement of urethral catheter if the use of the catheter is reasonable and necessary for the active treatment of a disease of the urinary tract or for patients with special medical needs. Skilled nursing is not considered medically necessary when urethral catheters are used only for the convenience or the control of incontinence. Since your catheter was inserted for convenience or the control of your incontinence, we believe that your care is not covered under Medicare.

Not applicable per PPS Interim Final Rule

SNF-8
Condition—Repetitive exercises—partial denial.
Paragraph—Medicare covers medically necessary skilled rehabilitation services. The medical information shows that the only therapy services you needed beginning (Date) were repetitive exercises and help with walking. These do not generally require the skills or the supervision of a qualified therapist. There was no evidence of medical complications which would have required that services be performed by a qualified therapist. We believe therapy services are not covered under Medicare after (Date).

SNF-9
Condition—Therapy services for overall fitness and well-being. (Skilled therapy is physical therapy, occupational therapy, and/or speech-language pathology).
Paragraph—Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. The therapy services you received were for your overall fitness and general well-being. They did not require the skills of a qualified (specify) therapist to perform and/or to supervise the services. Since you did not need skilled nursing or skilled rehabilitation services, we believe your stay is not covered under Medicare.

SNF-10

Condition—Therapy to maintain function after a maintenance program has been established.

Paragraph—Medicare covers medically necessary skilled rehabilitation services to establish a safe and effective program to maintain your functional abilities. This program was established and beginning (Date), the (specify) therapy services you received were to carry out this program. These services do not require the supervision or skills of a (specify) therapist and, therefore, we believe that the services are not/would not be covered under Medicare.

SNF-11

Condition—Specific skilled service is not reasonable and necessary (service not specific or effective).

Paragraph—Medicare covers medically necessary skilled care when needed on a daily basis. The (specify service(s)) you received is/are considered a skilled service by Medicare. However, based on the medical information provided, this/these services(s) is/are not considered a specific and/or effective treatment for your condition. Since the services(s) you received was/were not reasonable or necessary for the treatment of your condition, we believe your stay is not covered under Medicare.

SNF-12

Condition—No material improvement in relation to therapy services required—full denial.

Paragraph—Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. The (specify) therapy services provided was/were not reasonable in relation to the expected improvement in your condition. In this case, since you do not need skilled nursing on a daily basis and the therapy services are not considered reasonable and necessary, we believe, your stay is not covered under Medicare.

SNF-13

Condition—No material improvement in relation to therapy services required—partial denial.

Paragraph—Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. While you required skilled (specify) therapy from (Date) to (Date), the medical information shows that the (specify) therapy services after that time is not reasonable in relation to the expected improvement in your condition. In this case, since you do not need skilled nursing on a daily basis and the therapy services are not considered reasonable and necessary, we believe, your stay after (Date) is not covered under Medicare.

SNF-14

Condition—Frequency not reasonable and necessary.

Paragraph—Medicare covers medically necessary skilled care when needed on a daily basis. Although (specify service) generally requires the skills of a (nurse, physical therapist, speech-language pathologist, occupational therapist), the frequency with which the service is given must be in accordance with accepted standards of medical practice. The service(s) you received is/are not normally needed on a daily basis. The medical information does not show medical complications which require the services to be performed on a daily basis. In this case, the services are not considered reasonable and necessary. Since you did not need skilled nursing or skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare.

SNF-15

Condition—Skilled rehabilitation services not received daily—no skilled nursing.

Paragraph—Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. Although you required skilled (specify) therapy, you did not receive therapy on each day that it was available in the facility. Therefore, you do not meet the requirement for daily skilled rehabilitation services. Since you also did not need daily skilled nursing, we believe that your stay is not covered under Medicare.

SNF-16

Condition—Skilled nursing services not daily.

Paragraph—Medicare covers medically necessary skilled care needed on a daily basis. Although you required skilled nursing services, you do/did not need them on a daily basis. Because you do/did not need daily skilled nursing or skilled rehabilitation, we believe Medicare will not cover your stay.

Skilled Nursing Facility's Name and Address
Telephone number and TTY/TDD number

Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)

Date of Notice: _____

NOTE: You need to make a choice about receiving these health care items or services.

It is not Medicare's opinion, but our opinion, that Medicare will not pay for the items or services described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason to receive it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**.

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $** _____), in case you have to pay for them yourself or through other insurance you may have.
  Your other insurance is: _____
- If in 90 days you have not gotten a decision on your claim, contact the Medicare contractor at: Address: _____
  or at: Telephone: _____ TTY/TDD: _____
- If you receive these items or services, we will submit your claim for them to Medicare.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **DATE & SIGN** THIS NOTICE.

☐ **Option 1. YES. I want to receive these items or services.** I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision.

☐ **Option 2. NO. I will not receive these items or services.** I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay. I understand that, in the case of any physician-ordered items or services, should notify my doctor who ordered them that I did not receive them.

Patient's Name: _____ **Patient Identification #:** _____

_____ _____

Date **Signature of the patient or of the authorized representative**

Form CMS-10055

{Insert provider contact information here}
Notice of Medicare Non-Coverage

Patient name: **Patient number:**

The Effective Date Coverage of Your Current **{insert type}** Services Will End: **{insert effective date}**

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: {insert QIO name and toll-free number of QIO} to appeal, or if you have questions.

See page 2 of this notice for more information.

Form CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

  Plan contact information _____
  _____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_____ _____
Signature of Patient or Representative Date

Form CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953

Insert contact information here

Detailed Explanation of Non-coverage

Date:

Patient name: Patient number:

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined Medicare coverage for your current services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current {insert type} services should end.

• The facts used to make this decision:

• Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

• Plan policy, provision, or rationale used in making the decision (health plans only):

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at: {insert provider/plan toll-free telephone number}

Form CMS-10124-DENC (Approved 12/31/2011) OMB Approval No. 0938–0953

Health Insurance PPS (HIPPS) Codes

Since the onset of SNF PPS, SNF staff have been required to report on the claim form the HIPPS rate code for each PPS MDS completed. The first three positions of the HIPPS code represent the RUG group; the last two digits, the HIPPS assessment indicator (AI) code, represent the type of assessment.

The HIPPS code is based on the coding for MDS item A0310, which identifies the reason or reasons for the assessment. The first AI digit indicates PPS assessment completed to meet the scheduled assessment requirement (5-day, 30-day, etc.).

1st Digit Values	Assessment Type (abbreviation)
0	Unscheduled PPS assessment (unsched)
1	PPS 5-day or readmission return (5d or readm)
2	PPS 14-day (14d)
3	PPS 30-day (30d)
4	PPS 60-day (60d
5	PPS 90-day (90d)
6	OBRA assessment (not coded as a PPS assessment) **

**In some cases, such an assessment may be used for PPS if it is later determined that qualification for Part A coverage was present at the time of the assessment (see Missed Assessment, section 6.8). For these assessments A0310A will be 01 to 06 and A0310B will be 99.

Source: *Long-Term Care Facility Resident Assessment Instrument User's Manual,* chapter 6.

Often, a scheduled PPS assessment is combined with another assessment used for SNF PPS. The second AI digit indicates the unscheduled reason for assessment, if applicable.

Second Digit Values	Assessment Type	Must Be Combined With	Must NOT Be Combined With
0	Scheduled PPS assessment OBRA assessment		Another PPS assessment Unscheduled OBRA assessment PPS assessment
1	Unscheduled OBRA or Swing Bed CCA		• Any OMRA • Medicare Short Stay
2	Start of Therapy OMRA		• Medicare Short Stay • End of Therapy OMRA • Unscheduled OBRA • Swing Bed CCA
3	Start of Therapy OMRA	• Unscheduled OBRA *or* • Swing Bed CCA	• Medicare Short Stay • End of Therapy OMRA
4	End of Therapy OMRA not reporting resumption of therapy, whether or not combined with unscheduled OBRA or Swing Bed CCA		• Start of Therapy OMRA • Medicare Short Stay • End of Therapy OMRA reporting resumption of therapy
5	Start of Therapy OMRA	End of Therapy OMRA not reporting resumption of therapy	• Medicare Short Stay • Unscheduled OBRA • Swing Bed CCA • End of Therapy OMRA reporting resumption of therapy
6	Start of Therapy OMRA	• End of Therapy OMRA not reporting resumption of therapy *and* either • Unscheduled OBRA *or* • Swing Bed CCA	• Medicare Short Stay • End of Therapy OMRA reporting resumption of therapy
7	Medicare Short Stay	See detailed requirements for this assessment in AANAC manual *PPS Timing and Scheduling for the MDS 3.0*	
A	End of Therapy OMRA reporting resumption of therapy (EOT-R), whether or not combined with unscheduled OBRA or Swing Bed CCA		• Start of Therapy OMRA • Medicare Short Stay

B	Start of Therapy OMRA	End of Therapy OMRA	• Medicare Short Stay • Unscheduled OBRA • Swing Bed CCA
C	Start of Therapy OMRA	End of Therapy OMRA reporting resumption of therapy (EOT-R) and combined with either unscheduled OBRA or Swing Bed CCA	• Medicare Short Stay
D	Change of Therapy OMRA, whether or not combined with unscheduled OBRA or Swing Bed CCA		

Adapted from the *Long-Term Care Facility Resident Assessment Instrument User's Manual,* chapter 6.

Additional Development Request Checklist

Date Received _____
Date Sent to FI/MAC _____

Resident's Name: _____
Diagnosis: _____

NOTE: Requested documentation must reach the FI/MAC within 30 days of the date the ADR was sent to the facility. Send all ADR response by Certified Mail.

Signature of Person Completing Form _____

Documentation List	OK	Missing	N/A	Corrected
1. UB-04 for Dates of Service requested; dates correspond with ARDs				
2. Hospital documentation to support level of care				
• Interfacility transfer form				
• Discharge summary				
• MARs				
• IV records				
• Other _____				
3. Admission History and Physical				
4. Physician Certification/Recertification (signed/dated)				
5. Physician's Orders, include telephone orders				
6. Physician Progress Notes, include consults, ER visits				
7. Rehabilitation Therapy				
a. Evaluation Order (signed)				
b. Treatment Plan (signed)				
c. Progress Notes				
d. Treatment Logs showing treatment minutes				
8. Nursing Records				
a. Progress Notes				
b. Care Plans				
c. Medication Administration Records				
d. Treatment sheets				
e. CNA flow sheets/ADL Documentation				
f. Other clinical flow sheets _____				
g. Assessment sheets: B&B, skin, fall, hydration				
h. Other assessment sheets _____				
9. Mood and Depression				
a. Nursing Notes				
b. Social Services				
c. Activities Notes				
d. Rehab Notes				
e. Dietary Notes				
f. Physician notes/diagnosis				
10. Wound Care				
a. Physician orders/diagnosis				
b. Treatment Sheets				
c. Assessments sheets				
11. Nutrition Deficit				
a. Dietary notes				
b. Meal intake records				
c. Intake & Output Records (tube feedings)				
d. Rehab/Restorative notes				
12. Activities Notes				
13. CAAs for the dates of service reviewed				
14. Lab, x-ray, other diagnostic results				

Source: © 2010 RRS Healthcare Consulting Services

Perils and Pitfalls of the MDS/PPS Process Billing

Documentation to support billing for treatment and services:
Code the MDS from the chart documentation, not the other way around.

✓ Billing for skilled rehab when chart and/or MDS (G0900) indicate no rehab potential	✓ MDS shows IV fluids in the look-back into the hospital, but chart documentation does not support it
✓ Billing for gait training for poor endurance or weakness without documentation of muscular, ortho, or neuro necessity	✓ MDS shows depression but chart lacks specific incidences of signs and symptoms
✓ Billing for skilled therapy for > two weeks with little or no documented progress	✓ Billing unnecessary significant change of status assessments
✓ ST treats for swallow, but swallowing problem is not checked on MDS (K0100) and/or not documented in chart	✓ Therapy logs don't match therapy minutes (O0400)
✓ ST treats for communication deficit, but B0700 on MDS and chart documentation indicate making self understood	✓ Rehab charges for gait training while CNAs document steady ad lib ambulation
✓ Inconsistent ARD among disciplines	✓ MDS ARD and/or UB-04 service date inaccurate due to leave-of-absence days
✓ Long-term, low-level functioning in cognition (C0500), behavior (E), and/or ADLs (G0110) calls into question rehab potential	✓ Failure to capture off-cycle assessments for billing; inaccurate off-cycle assessment coverage dates
✓ Inaccurate or false information that results in higher RUG category, such as ADL score or depression status	✓ Inaccurate number of covered days on UB-04 due to LOA
✓ MDS shows tube feeding with 26% of calories/501 cc fluids provided, but chart I&O does not consistently support it	✓ Inaccurate HIPPS codes
✓ Wound (M0300) and wound care (M1200) coded on MDS, but treatment sheets show inconsistent treatments	✓ MDS shows s/s depression (PHQ-9), but no antidepressant (N0410C) or psychological therapy (O0410E) and/or no chart documentation

Remember . . .
If the provider knows about a pattern of improper billing and fails to take action—or if the provider **should have known about it**—it still constitutes fraud or abuse.

Medicare Secondary Payer Questionnaire

Medicare Secondary Payer Manual
Chapter 3: MSP Provider Billing Requirements
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf
Excerpt

Section 20.1—General Policy

Based on the law and regulations, providers, physicians, and other suppliers are required to file claims with Medicare using billing information obtained from the beneficiary to whom the item or service is furnished. Section 1862(b)(6) of the Act, (42 USC 1395y(b)(6)), requires all entities seeking payment for any item or service furnished under Part B to complete, on the basis of information obtained from the individual to whom the item or service is furnished, the portion of the claim form relating to the availability of other health insurance. Additionally, 42 CFR 489.20(g) requires that all providers must agree "to bill other primary payers before billing Medicare."

Thus, any providers, physicians, and other suppliers that bill Medicare for services rendered to Medicare beneficiaries must determine whether or not Medicare is the primary payer for those services. This must be accomplished by asking Medicare beneficiaries, or their representatives, questions concerning the beneficiary's MSP status. Exceptions to this requirement are discussed below in 1 and 3. If providers, physicians or other suppliers fail to file correct and accurate claims with Medicare, and a mistaken payment situation is later found to exist, 42 CFR 411.24 permits Medicare to recover its conditional or mistaken payments.

Section 20.2.1, "Admission Questions to Ask Medicare Beneficiaries," may be used to determine the correct primary payers of claims for all beneficiary services furnished by a hospital.

NOTE: Providers are required to determine whether Medicare is a primary or secondary payer for each inpatient admission of a Medicare beneficiary and outpatient encounter with a Medicare beneficiary prior to submitting a bill to Medicare. It must accomplish this by asking the beneficiary about other insurance coverage. Section 20.2.1 lists the type of questions it must ask of Medicare beneficiaries for **every** admission, outpatient encounter, or start of care. Exceptions to this requirement are discussed below in 1 and 3.

EXCEPTIONS

These questions may be asked in connection with online access to Common Working File (CWF). (See §20.2.) If the provider lacks access to CWF, it will follow the procedures found in §20.2.1.

NOTE: There may be situations where more than one payer is primary to Medicare (e.g., liability insurer and GHP). The provider, physician, or other supplier must identify all possible payers. This greatly increases the likelihood that the primary payer is billed correctly. Verifying MSP information means confirming that the information previously furnished about the presence or absence of another payer that may be primary to Medicare is correct, clear, and complete, and that no changes have occurred.

Section 20.2.1—Admission Questions to Ask Medicare Beneficiaries

The following questionnaire contains questions that can be used to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers may use this as a guide to help identify other payers that may be primary to Medicare. This questionnaire is a model of the type of questions that may be asked to help identify Medicare Secondary Payer (MSP) situations. If you choose to use this questionnaire, please note that it was developed to be used in sequence. Instructions are listed after the questions to facilitate transition between questions. The instructions will direct the patient to the next appropriate question to determine MSP situations.

PART I

1. Are you receiving Black Lung (BL) Benefits?

___ Yes; Date benefits began: MM/DD/CCYY

BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL.

___ No.

2. Are the services to be paid by a government research program?

___ Yes.

GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.

___ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?

___ Yes.

DVA IS PRIMARY FOR THESE SERVICES.

___ No.

4. Was the illness/injury due to a work-related accident/condition?

___ Yes; Date of injury/illness: MM/DD/CCYY

Name and address of workers' compensation plan (WC) plan:

_____

_____

_____

_____

Policy or identification number: _____

Name and address of your employer:

_____

_____

_____

_____

WC IS PRIMARY PAYER ONLY FOR CLAIMS FOR WORK-RELATED INJURIES OR ILLNESS, GO TO PART III.
___ No. **GO TO PART II.**

PART II

1. Was illness/injury due to a non-work-related accident?

___ Yes; Date of accident: MM/DD/CCYY
___ No. **GO TO PART III**

2. Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)

___Yes.
Name and address of no-fault insurer(s) and no-fault insurance policy owner:
_____
_____
_____
_____
_____
_____
Insurance claim number(s): _____
___ No.

3. Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)

___Yes.
Name and address of liability insurer(s) and responsible party:
_____
_____
_____
_____
_____
_____
_____
_____
Insurance claim number(s): _____
___ No.

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE ACCIDENT. LIABILITY INSURANCE IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE LIABLITY SETTLEMENT, JUDGMENT, OR AWARD. GO TO PART III.

PART III

1. Are you entitled to Medicare based on:

___ Age. **Go to PART IV.**
___ Disability. **Go to PART V.**
___ End-Stage Renal Disease (ESRD). **Go to PART VI.**

Please note that both "Age" and "ESRD" OR "Disability" and "ESRD" may be selected simultaneously. An individual cannot be entitled to Medicare based on "Age" and "Disability" simultaneously. Please complete ALL "PARTS" associated with the patient's selections.

PART IV—AGE

1. Are you currently employed?

___ Yes.
Name and address of your employer:

_____
_____
_____
_____
___ No. If applicable, date of retirement: MM/DD/CCYY
___ No. Never Employed.

2. Do you have a spouse who is currently employed?

___ Yes.
Name and address of your spouse's employer:

_____
_____
_____
_____
___ No. If applicable, date of retirement: MM/DD/CCYY
___ No. Never Employed.

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

___ Yes, both.
___ Yes, self.
___ Yes, spouse.

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

4. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees?

___ Yes. **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

_____
_____
_____
_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

___ No.

5. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 20 or more employees?

___ Yes. **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

_____
_____
_____
_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

___ No.

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 4 AND 5, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

PART V – DISABILITY

1. Are you currently employed?

___ Yes.

Name and address of your employer:

_____

_____

_____

_____

___ No. If applicable, date of retirement: MM/DD/CCYY

___ No. Never Employed.

2. Do you have a spouse who is currently employed?

___ Yes.

Name and address of your spouse's employer:

_____

_____

_____

_____

___ No. If applicable, date of retirement: MM/DD/CCYY

___ No. Never Employed.

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

___ Yes, both.

___ Yes, self.

___ Yes, spouse.

___ No.

4. Are you covered under the GHP of a family member other than your spouse?

___ Yes.

Name and address of your family member's employer:

_____

_____

_____

_____

___ No.

IF THE PATIENT ANSWERED "NO" TO QUESTIONS 1, 2, 3, AND 4, STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR 11.

5. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 100 or more employees?

___ Yes. **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

_____
_____
_____
_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

___ No.

6. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 100 or more employees?

___ Yes. **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

_____
_____
_____
_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

___ No.

7. If you have GHP coverage based on a family member's current employment, does your family member's employer, that sponsors or contributes to the GHP, employ 100 or more employees?

___ Yes. **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

_____
_____
_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____
Group identification number: _____
Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____
Name of policyholder/named insured: _____
Relationship to patient: _____

___ No.

IF THE PATIENT ANSWERED "NO" TO QUESTIONS 5, 6, and 7, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

PART VI – ESRD

1. Do you have group health plan (GHP) coverage?

___ Yes.

IF APPICABLE, YOUR GHP INFORMATION:
Name and address of GHP:

_____
_____
_____
_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number: _____
Group identification number: _____
Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____
Name of policyholder /named insured: _____
Relationship to patient: _____
Name and address of employer, if any, from which you receive GHP coverage:

_____
_____
_____
_____

IF APPICABLE, YOUR SPOUSE'S GHP INFORMATION:
Name and address of GHP:

_____
_____
_____
_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number: _____
Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____
Name of policyholder /named insured: _____
Relationship to patient: _____
Name and address of employer, if any, from which your spouse receives GHP coverage:
IF APPICABLE, YOUR FAMILY MEMBER'S GHP INFORMATION:
Name and address of GHP:

_____
_____
_____
_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number: _____
Group identification number: _____
Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____
Name of policyholder /named insured: _____
Relationship to patient: _____
Name and address of employer, if any, from which your family member receives GHP coverage:

_____
_____
_____
_____

___ No. **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?
___ Yes. Date of transplant: MM/DD/CCYY
___ No.

3. Have you received maintenance dialysis treatments?
___ Yes. Date dialysis began: MM/DD/CCYY
If you participated in a self-dialysis training program, provide date training started: MM/DD/CCYY

___ No.

4. Are you within the 30-month coordination period that starts MM/DD/CCYY? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis). If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)

___ Yes.
___ No. **STOP. MEDICARE IS PRIMARY.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

___ Yes.
___ No.

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

___ Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
___ No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP already primary based on age or disability entitlement)?

___ Yes. **GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
___ No. **MEDICARE CONTINUES TO PAY PRIMARY.**

If no MSP data are found in the Common Working File (CWF) for the beneficiary, the provider still asks the types of questions above and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.

Editor's note: For additional information on provider requirements for establishing MSP eligibility, including documentation retention, see sections 20.1, 20.2, and 20.2.2 of Chapter 3 in the Medicare Secondary Payer Manual. ***All seven chapters of the MSP Manual can be accessed at*** **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html.**

Physician Certification and Recertification

Medicare General Information, Eligibility, and Entitlement Manual
Chapter 4: "Physician Certification and Recertification of Services"

Sect. 40—Certification and Recertification by Physicians for Extended-Care Services

Payment for covered posthospital extended care services may be made only if a physician makes the required certification and, where services are furnished over a period of time, the required recertification regarding the services furnished.

The skilled nursing facility is responsible for obtaining the required physician certification and recertification statements and for retaining them in file for verifications, if needed, by the intermediary. The skilled nursing facility determines the method by which the physician certification and recertification statements are to be obtained. There is no requirement that a specific procedure or specific forms be used, as long as the approach adopted by the facility permits a verification to be made that the certification and recertification requirements are in fact met. Certification and recertification statements may be entered on or included in forms, NOTEs, or other records a physician normally signs in caring for a patient, or a separate form may be used. Except as otherwise specified, each certification and recertification statement is to be separately signed by a physician.

If the facility's failure to obtain a certification or recertification is not due to a question as to the necessity for the services, but rather to the physician's refusal to certify based on other grounds (e.g., he objects in principle to the concept of certification and recertification), the facility may not bill the program or the beneficiary for covered items or services. The provider agreement which the facility files with the Secretary precludes it from charging the patient for covered items and services.

If a physician refuses to certify because, in his/her opinion, the patient does not require skilled care on a continuing basis for a condition for which he/she was receiving inpatient hospital services, the services are not covered and the facility can bill the patient directly. The reason for the physician's refusal to make the certification must be documented in the facility records. For such documentation to be adequate, there must be some statement in the facility's records, signed by a physician or a responsible facility official, indicating that the patient's physician feels that the patient does not require skilled care on a continuing basis for any of the conditions for which he/she was hospitalized.

Sect. 40.1—Who May Sign the Certification or Recertification for Extended-Care Services

(Rev. 76, Issued: 01-13-12, Effective: 01-01-11, Implementation: 02-13-12)

A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case, or by a nurse practitioner or a clinical nurse specialist (or, effective with items and services furnished on or after January 1, 2011, a physician assistant) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician.

Ordinarily, for purposes of certification and recertification, a "physician" must meet the definition contained in Chapter 5, §70 of this manual.

Sect. 40.2—Certification for Extended-Care Services

The certification must clearly indicate that posthospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled care on a continuing basis for any of the conditions for which he/she was receiving inpatient hospital services, including services of an emergency hospital (see Chapter 5, §20.2) prior to transfer to the SNF. Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. The routine admission procedure followed by a physician would not be sufficient certification of the necessity for post-hospital extended care services for purposes of the program.

If ambulance service is furnished by a skilled nursing facility, an additional certification is required. It may be furnished by any physician who has sufficient knowledge of the patient's case, including the physician who requested the ambulance or the physician who examined the patient upon his arrival at the facility. The physician must certify that the ambulance service was medically required.

Sect. 40.3—Recertifications for Extended-Care Services

The recertification statement must contain an adequate written record of the reasons for the continued need for extended care services, the estimated period of time required for the patient to remain in the facility, and any plans, where appropriate, for home care. The recertification statement made by the physician does not have to include this entire statement if, for example, all of the required information is in fact included in progress notes. In such a case, the physician's statement could indicate that the individual's medical record contains the required information and that continued posthospital extended care services are medically necessary. A statement reciting only that continued extended care services are medically necessary is not, in and of itself, sufficient.

If the circumstances require it, the first recertification and any subsequent recertifications must state that the continued need for extended care services is for a condition requiring such services which arose after the transfer from the hospital and while the patient was still in the facility for treatment of the condition(s) for which he/she had received inpatient hospital services.

Sect. 40.4—Timing of Recertifications for Extended-Care Services

The first recertification must be made no later than the l4th day of inpatient extended care services. A skilled nursing facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the l4-day period by diagnostic or clinical categories. Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the utilization review committee and the skilled nursing facility.

At the option of the skilled nursing facility, review of a stay of extended duration, pursuant to the facility's utilization review plan (if a UR review plan is in place), may take the place of the second and any subsequent physician recertifications. The skilled nursing facility should have available in its files a written description of the procedure it adopts with respect to the timing of recertifications. The procedure should specify the intervals at which recertifications are required, and whether review of long-stay cases by the utilization review committee serves as an alternative to recertification by a physician in the case of the second or subsequent recertifications.

Sect. 40.5—Delayed Certifications and Recertifications for Extended-Care Services

Skilled nursing facilities are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an isolated oversight or lapse.

In addition to complying with the content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the skilled nursing facility considers relevant for purposes of explaining the delay. The facility will determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification would not be required as they would if timely certification and recertification had been made.

Sect. 40.6—Disposition of Certification and Recertifications for Extended-Care Services

Skilled nursing facilities do not have to transmit certification and recertification statements to the intermediary; instead, the facility must itself certify, in the admission and billing form, that the required physician certification and recertification statements have been obtained and are on file.

Examples of Skilled Nursing and Rehabilitation Services

42 *Code of Federal Regulations* §409.33

(a) *Services that could qualify as either skilled nursing or skilled rehabilitation services.*

(1) Overall management and evaluation of care plan.
(i) When overall management and evaluation of care plan constitute skilled services. The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel.

(ii) Example. An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition supports a finding that recovery and safety can be ensured only if the total care is planned, managed, and evaluated by technical or professional personnel, it is appropriate to infer that skilled services are being provided.

(2) Observation and assessment of the patient's changing condition.
(i) When observation and assessment constitute skilled services. Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized.

(ii) Examples. A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic

measures. Similarly, surgical patients transferred from a hospital to an SNF while in the complicated, unstabilized postoperative period, for example, after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications and adverse reaction. Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, may also require skilled observation and assessment by technical or professional personnel to ensure their safety or the safety of others, that is, to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented by physicians' orders or nursing or therapy notes.

(3) Patient education services.

(i) When patient education services constitute skilled services. Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance.

(ii) Examples.

(a) A patient who has had a recent leg amputation needs skilled rehabilitation services provided by technical or professional personnel to provide gait training and to teach prosthesis care. Similarly, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self administration of insulin or foot-care precautions.

(b) *Services that qualify as skilled nursing services*.

(1) Intravenous or intramuscular injections and intravenous feeding.

(2) Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day.

(3) Nasopharyngeal and tracheostomy aspiration;

(4) Insertion and sterile irrigation and replacement of suprapubic catheters;

(5) Application of dressings involving prescription medications and aseptic techniques;

(6) Treatment of extensive decubitus ulcers or other widespread skin disorder.

(7) Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress;

(8) Initial phases of a regimen involving administration of medical gases;

(9) Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.

(c) *Services which would qualify as skilled rehabilitation services*.

(1) Ongoing assessment of rehabilitation needs and potential: Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders;

(2) Therapeutic exercises or activities: Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment;

(3) Gait evaluation and training: Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;

(4) Range of motion exercises: Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored);

(5) Maintenance therapy; Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning.

(6) Ultrasound, short-wave, and microwave therapy treatment by a qualified physical therapist;

(7) Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool; Hot pack hydrocollator, infrared treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required; and

(8) Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

(d) *Personal care services*. Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in §409.32(b). Personal care services include, but are not limited to, the following:

(1) Administration of routine oral medications, eye drops, and ointments;

(2) General maintenance care of colostomy and ileostomy;

(3) Routine services to maintain satisfactory functioning of indwelling bladder catheters;

(4) Changes of dressings for noninfected postoperative or chronic conditions;

(5) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

(6) Routine care of the incontinent patient, including use of diapers and protective sheets;

(7) General maintenance care in connection with a plaster cast;

(8) Routine care in connection with braces and similar devices;

(9) Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator;

(10) Routine administration of medical gases after a regimen of therapy has been established;

(11) Assistance in dressing, eating, and going to the toilet;

(12) Periodic turning and positioning in bed; and

(13) General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking do not constitute skilled rehabilitation services.

Source:
[48 FR 12541, Mar. 25, 1983, as amended at 63 FR 26307, May 12, 1998; 64 FR 41681, July 30, 1999]

Jimmo v. Sebelius Settlement Agreement
Fact Sheet

Overview:
On January 24, 2013, the U. S. District Court for the District of Vermont approved a settlement agreement in the case of *Jimmo v. Sebelius*, in which the plaintiffs alleged that Medicare contractors were inappropriately applying an "Improvement Standard" in making claims determinations for Medicare coverage involving skilled care (e.g., the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) benefits). The settlement agreement sets forth a series of specific steps for the Centers for Medicare & Medicaid Services (CMS) to undertake, including issuing clarifications to existing program guidance and new educational material on this subject. The goal of this settlement agreement is to ensure that claims are correctly adjudicated in accordance with existing Medicare policy, so that Medicare beneficiaries receive the full coverage to which they are entitled.

Background:
In the case of *Jimmo v. Sebelius*, the Center for Medicare Advocacy (CMA) alleged that Medicare claims involving skilled care were being inappropriately denied by contractors based on a rule-of-thumb "Improvement Standard"—under which a claim would be summarily denied due to a beneficiary's lack of restoration potential, even though the beneficiary did in fact require a covered level of *skilled care* in order to prevent or slow further deterioration in his or her clinical condition. In the *Jimmo* lawsuit, CMS denied establishing an improper rule-of-thumb "Improvement Standard." The Court never ruled on the validity of the *Jimmo* plaintiffs' allegations.

While an expectation of improvement would be a reasonable criterion to consider when evaluating, for example, a claim in which the goal of treatment is restoring a prior capability, Medicare policy has long recognized that there may also be specific instances where no improvement is expected but skilled care is, nevertheless, required in order to prevent or slow deterioration and maintain a beneficiary at the maximum practicable level of function. For example, in the regulations at 42 CFR 409.32(c), the level of care criteria for SNF coverage specify that the ". . . restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities."

The Medicare statute and regulations have never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. A beneficiary's lack of restoration potential cannot, in itself, serve as the basis for denying coverage, without regard to an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question. Conversely, coverage in this context would not be available in a situation where the beneficiary's care needs can be addressed safely and effectively through the use of *nonskilled* personnel.

Thus, such coverage depends not on the beneficiary's restoration potential, but on *whether skilled care is required*, along with the underlying reasonableness and necessity of the services themselves. Any Medicare coverage or appeals decisions concerning skilled care coverage must reflect this basic principle. In this context, it is also essential and has always been required that claims for skilled care coverage include sufficient documentation to substantiate clearly that skilled care is required, that it is in fact provided, and that the services themselves are reasonable and necessary, thereby facilitating accurate and appropriate claims adjudication.

The Settlement Agreement - ***No Expansion of Medicare Coverage:***
The *Jimmo v. Sebelius* settlement agreement itself includes language specifying that **"Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage."**

The settlement agreement is intended to clarify that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration. As such, any actions undertaken in connection with this settlement do not represent an *expansion* of coverage, but rather, serve to clarify *existing* policy so that Medicare claims will be adjudicated consistently and appropriately.

Forthcoming Activities:
CMS plans to conduct the following activities under the terms of the settlement agreement:

Clarifying Policy – Updating Program Manuals
The first action CMS will undertake as specified in the settlement agreement will be revising the relevant program manuals used by Medicare contractors. The Medicare program manuals will be reworded for clarity, so as to reinforce the intent of the policy. Specifically, in accordance with the settlement agreement, manual revisions will clarify that coverage of therapy "…does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care."

Educational Campaign – Informing Stakeholders
The next step CMS will take will be an educational campaign for contractors, adjudicators, and providers and suppliers. CMS will disseminate to these recipients a variety of written materials, including:

- Program Transmittal;
- Medicare Learning Network (MLN) Matters article;
- Updated 1-800 MEDICARE scripts.

CMS will also conduct national conference calls with providers and suppliers as well as Medicare contractors, Administrative Law Judges, medical reviewers, and agency staff, to communicate the policy clarifications described herein and answer questions.

Claims Review
In addition, to ensure beneficiaries receive the care to which they are entitled, CMS will engage in accountability measures, including review of a random sample of SNF, HH, and OPT coverage decisions to determine overall trends and identify any problems, as well as a review of individual claims determinations that may not have been made in accordance with the principles set forth in the settlement agreement.

According to the terms of the settlement agreement, CMS will complete the manual revisions and educational campaign by January 23, 2014, which is within one year of the approval date of the settlement agreement.